Patient sexual orientation and gender identity disclosure

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A. Jamieson [1], H. Cross[1], S. Arthur[1], K. Nambiar[2] CD. Llewellyn[1]

1- Department of Primary Care and Public Health, Brighton and Sussex Medical School, Brighton BN1 9PH

2-Brighton and Sussex University Hospital NHS Trust, Eastern Road, Brighton, BN2 5BE

Key words: medical education; LGBT; sexual orientation; gender identity; curriculum

PULLOUT QUOTES:

LGBT people are disproportionately affected by a range of physical and mental health conditions.

There are limited data regarding UK medical students' perceptions of sexual orientation and gender identity non-disclosure to HCPs.

The majority of participants thought that a HCP should know a patient's gender identity.

When gender identity or sexual orientation is known, HCPs can provide better holistic care.

Participants recognised heteronormative environments as a barrier for LGB patients accessing relevant health advice

Participants were aware of *"discrimination" (Y1P1)* and *"heteronormative language" (Y5P3)* as reasons for non-disclosure

Participants felt that collecting sexual orientation information on registration forms is acceptable

Abstract

Background

In the United Kingdom (UK), 2.3% of men and 1.6% of women identify as lesbian, gay or bisexual (LGB). One percent of the UK population are estimated to identify as transgender (T). 46% of the LGB population do not disclose their sexual orientation to healthcare professionals (HCPs) and 18% of transgender patients avoid healthcare altogether. Non-disclosure of sexual orientation and/or gender identity contributes to worse health outcomes for LGBT patients.

Objectives

This study aimed to explore medical students' perceptions of the barriers to healthcare for LGBT patients and the importance of patient disclosure of sexual orientation or gender identity.

Methods

Focus groups included medical students across five year groups from a a medical school in the South East of England. Discussions followed a pre-approved topic guide with a primary and co-facilitator present. Focus groups were audio-recorded, transcribed verbatim, and data underwent framework analysis.

Results

Forty-five undergraduate medical students participated (40% non-heterosexual). Most participants believed that incorrect use of pronouns and discrimination would be a cause for non-disclosure of gender identity and sexual orientation to HCPs.. Several participants thought it was more important to know a patient's gender identity than

sexual orientation. Many participants felt that collecting sexual orientation information on registration forms is acceptable.

Discussion

More education regarding LGBT health needs and ways to encourage patient disclosure of sexual orientation or gender identity should be included in the undergraduate medical school curricula to increase future doctors' competency when interacting with LGBT patients.

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Introduction

The National Lesbian, Gay, Bisexual and Transgender (LGBT) Partnership in England uses the term LGBT to define different sexual or gender identities.[1] The Office of National Statistics reports that 2% of the total United Kingdom (UK) population self-identified as non-heterosexual in 2017.[2] Although UK legislation is clear that discrimination on the grounds of sexual or gender identity is unlawful, prejudice and discrimination still exist in society,no robust and representative data of the LGBT population in the UK currently exists. [3] . The National LGBT Survey reported that 46% of LGBT participants had not disclosed their sexual orientation to a healthcare professional (HCP).[3] LGBT people are disproportionately affected by a range of physical and mental health conditions[4] with non-disclosure shown to be linked to worse outcomes.[5] The 'Personal Risk Theory' describes the decision to disclose one's sexual orientation or gender identity as a risk-benefit analysis: the outcome of disclosure (including the HCP's response) will alter the likelihood of disclosure in subsequent HCP interactions.[6] To ensure that sexual orientation is asked in a uniform, non-judgemental manner, the 2017 'Sexual Orientation Monitoring Information Standard' issued the wording that must be used when collecting sexual orientation and gender identity health data in the UK.

Avoidance of healthcare services may lead to worse health outcomes due to delayed diagnoses. LGBT patients have lower rates of cervical screening attendance and breast self-examination compared to heterosexual patients.[7] The barriers to disclosure and attendance at HCP appointments include: fears of confidentiality breaches, HCPs lacking

knowledge of specific LGBT needs, and a lack of holistic care beyond the realms of sexual health, homophobia and 'heteronormativity'; the assumption that heterosexuality is the norm, unless stated otherwise..[8]

Although research has been carried out into the LGBT curricula of United States and Canadian medical training institutions[9], there is currently limited available evidence on the overall state of LGBT teaching in the undergraduate curricula of UK medical schools. Recently, Stonewall's 'LGBT in Britain' survey report recommended that the "curricula, standards, and training" of medical schools should be reviewed in order to encompass mandatory teaching on the use of appropriate language and discrimination, LGBT health inequalities, and LGBT-inclusive care.[3] The aim of this study was to explore UK medical students' perceptions of the barriers to healthcare for LGBT patients and the importance of patient disclosure of sexual orientation or gender identity.

Methods

Design

Focus groups were used to allow detailed exploration of medical students' perceptions. Reporting guidelines were adhered to.[10]

Participants, sampling and recruitment

Between September and October 2018, all undergraduate medical students at a UK medical school, received invitations to take part in focus groups, using a convenience

sample. Participants were accepted on a first-come, first-served basis. A prize draw entry to win a £40 voucher was offered. Five focus groups were planned; one for each year of study.

Procedure

All focus groups were held on university premises. Every session was preceded by ground rules to ensure all comments were respectful and kept confidentialTwo facilitators (medical school undergraduates; one female (AJ), one male (HC)) organised and co-facilitated all groups. Both facilitators wore badges highlighting what their preferred pronouns were (He, She, They. for example) to empower participants to discuss gender identity freely. Pronoun badges were available for participants. Anonymised audio recordings were transcribed by the primary facilitator and read and verified by the co-facilitator. Focus group participants completed a short, anonymous, demographic questionnaire prior to the session to monitor their diversity and inclusivity with regards to gender, sexual and ethnic orientation Ethical approval was provided by the University (ER/BSMS4396/1). We obtained fully informed, written consent from participants.

A topic guide (appendix A) was drafted by AJ, HC, and CL to explore students' perceptions of the barriers to healthcare for LGBT patients and the importance of patient disclosure of sexual orientation or gender identity.. The topic guide was piloted with students who did not take part in the focus groups. CL provided training and

shadowing of the initial two focus groups to ensure competency of both facilitators in managing the focus groups and analysis.

Analysis

Framework analysis was conducted by both facilitators independently.[11] Themes were identified, guided by the topic guide and study aims. Quotes relating to each theme were indexed to form a thematic matrix. Data were interpreted and participants' responses were compared to one another. Themes were independently validated by each facilitator to ensure accurate interpretation within the context of the discussions. A third validator (CL), was available for any disagreements although none arose.

Findings

Five mixed gender focus groups including 45 participants were conducted (table 1); 60% of participants identified as heterosexual (table 2).

Themes

Four themes were identified (box 1):

1. Perceptions of the importance of HCPs knowing a patient's gender identity and sexual orientation (SO)

Opinions regarding the necessity of knowing a patient's sexual orientation or gender identity varied greatly. The majority of participants thought that a HCP should know a

patient's gender identity to ensure that relevant screening tests were provided*:* *"someone who has transitioned, they may still have a prostate and they may be an older guy and their likelihood of prostate cancer may still be there but if they're not on the system identified as like male anymore, then they might be missed on... screening" (Year 3, Participant 9 (Y3P9)).*

A minority of participants thought HCPs should not ask gender identity or sexual orientation for risk stratification purposes, and should instead ask about specific risk behaviours. "*Instead of asking 'are you gay?', [HCPs] should take the sexual history…" (Y5P3)*.

Participants mentioned that gender identity or sexual orientation should be asked *"only if it's medically necessary" (Y1P8)*. However, participants acknowledged that when gender identity or sexual orientation is known, HCPs can provide better holistic care. Several participants thought knowing a patient's gender identity is *"more important than… knowing a patient's sexual orientation"* because it enables HCPs to *"ask them what their pronouns are, and you [the HCP] avoid the risk of offending them by making assumptions" (Y3P3).*

2. Interaction with healthcare services

Participants recognised that the fear of receiving substandard care "*because of discrimination" (Y1P1)* could be a cause for non-disclosure of gender identity. Participants were aware that LGBT patients had *"less interaction with screening*

programmes… particularly cervical smears in lesbian and bisexual women" (Y4P2). They were also aware of *"issues surrounding access to routine screenings" (Y3P3)* for trans patients. Several participants recognised heteronormative environments as a barrier for LGB patients accessing relevant health advice: *"It's less likely for [a leaflet about practicing safe sex] to include useful information about… homosexual relationships" (Y2P10).*

Participants were aware of *"discrimination" (Y1P1)* and *"heteronormative language" (Y5P3)* as reasons for non-disclosure or *"less interaction with screening programmes" (Y4P2).* No participants mentioned the availability of Hepatitis A or HPV vaccines to men who have sex with men. Participants were not aware of factors that have been thought to encourage disclosure of sexual orientation or gender identity, including the HCPs demographics or longer appointment times. A minority of participants were aware of trans-specific clinics but had a limited understanding of what they involved and thought they were run by transgender doctors. One participant explained that she has witnessed LGBT patients being needlessly referred to sexual health clinics because this is *"the service which is comfortable [managing trans patients]" Y5P7* rather than being managed by GPs, like cis-patients would be.

Most students felt *"there should be more"* (*Y4P3)* LGBT specific education. Participants were also aware of a societal shift *"where we accept people who are gender fluid, whose sexuality is fluid" (Y1P3)* and thus expressed that *"the curriculum of all medical schools should reflect that" (Y1P3).*

<u>3. Methods to disclose sexual orientation to HCPs and their respective barriers.</u>

Most participants felt that collecting sexual orientation information on registration forms is acceptable, however, the understanding of the legislation behind gathering this information is generally poor. The universal collection of sexual orientation data was mentioned in years four and five. Several participants thought that "*it's up to the patient to disclose"* but that the HCP needs to "*be approachable and have the trust of the patient" (Y3P7).* Conversely, some participants described the *"onus of responsibility falls on you as the health care provider to take a complete history" (Y1P3)* including asking the sex about any sexual partners.

4. Misgendering of patients

During the focus groups, patients who describe their gender as the same as the sex they were assigned at birth (cisgender) were repeatedly referred to as '*normal' (Y1P4)* or were misgendered. *"Someone who has transitioned they may still have a prostate and they may be an older guy and their likelihood of prostate cancer may still be there but if they're not on the system identified as like male anymore, then they might be missed on... screening" Y3P9.* In this quote, the participant referred to a trans woman as a masculine "*guy*" *(Y3P9)*. This misgendering suggests students were not well informed of the differences between gender identity and biological sex.

Discussion

There are limited data regarding UK medical students' perceptions of sexual orientation and gender identity non-disclosure to HCPs. This is one of the first qualitative studies to

investigate UK medical students' perceptions of the importance and health impacts of disclosure of sexual orientation and gender identity in healthcare.

This study indicates that medical students' understanding of the importance of non-disclosure of sexual orientation or gender identity to HCPs is limited outside of sexual or mental health. These findings have directly helped to alter our curriculum through a newly convened Curriculum Development Group led by CDL to review the amount and content of diversity and inclusion in healthcare, with particular emphasis on LGBT issues, to our undergraduate students. This has been implemented in the first instance with a newly developed 'inequalities and inclusion in healthcare' component within our clinical and community practice modules in the pre-clinical phase. The broad aims of this strand developed by our academic GPs are to: raise awareness and improve understanding; develop a sense of social sensitivity and responsibility; and gain experience in a safe and supportive environment. This work has increased the momentum for change so that we can further develop teaching opportunities to present an integrated, comprehensive and considered inclusive and diverse experience to our students.

Limitations

This study recruited from one medical school, situated in an area of the UK with a larger than average LGBT population (circa 11-15% of the population over 16 years old)[12] which may have impacted on discussions. It is likely that the participants will have known each other and the facilitators due to a relatively small student cohort. This may have created a bias towards socially desirable answers.

The convenience sampling resulted in 40% of the participants identifying as non-heterosexual meaning they were likely to have greater preconceived knowledge levels of LGBT issues than other students. No obvious differences across year groups were observed.

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Competing interests

All authors declare no conflict of interest.

Contributions

AJ, HC, SA, CL and KN devised the study and sought ethical approval. AJ, HC recruited and facilitated focus groups with CL supervising. AJ, HC and CL were involved in data analysis and verification. AJ produced the first draft of the manuscript. AJ, HC, SA, CL and KN contributed to the final manuscript.

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1. Perceptions of the importance of HCPs knowing a patient's gender identity and SO
2. Interaction with healthcare services
3. Methods to disclose sexual orientation to HCPs and their respective barriers
4. Misgendering of patients.

Box 1: The four themes identified from our focus group

Table 1: Profile of each focus group (n=45)

Focus group	Number of participants	Age range (mean) in years
Year 1 (undergraduate)	9	18-31 (20.1)
Year 2 (undergraduate)	11	19-23 (20.3)
Year 3 (undergraduate)	10	20-24 (21.8)
Year 4 (undergraduate)	10	21-38 (23.9)
Year 5 (undergraduate)	5	22-24 (22.8)

Table 2: Characteristics of total focus group participants (n=45)

Characteristic	Number of participants	%
Age range (mean)	18-38 (21.7)	
Median age	21	
Female	30	66.7
Male	15	33.3
Gender different to gender assigned at birth	0	0
No religion	30	66.7
Christian	10	22.2
Buddhist	2	4.4
Muslim	3	6.7
Heterosexual or straight	27	60.0
Gay or lesbian	5	11.1
Bisexual	9	20.0
Other sexual orientation	4	8.9

Appendix A: Focus Group Topic Guide.

FOCUS GROUP TOPIC GUIDE

Medical students' attitudes, beliefs and knowledge of Lesbian, Gay, Bisexual and Transgender (LGB&T) patients' health needs and barriers to health services; a qualitative study.

Supervisors: C. Llewellyn, A. Pollard, K. Nambiar,
Investigators: H. Cross, A. Jamieson.

Establish verbal ground rules

Confidentiality and anonymity

Some of the things we will be discussing could be personal or controversial so we should all be respectful of others' views – even if we do not agree with them. We are all equal with different perspectives. Listen generously and please do not interrupt each other.

Please also be mindful of your own confidentiality – do not feel obliged to reveal any more than you feel comfortable sharing.

It's worth noting before we start that anything said in this group discussion will be kept confidential. Therefore, we ask you not to speak about individual responses once you leave the room. This is to ensure we create an environment that is safe for people to provide open and honest answers.

With your permission, we will be audio-recording our conversation today, but the written transcript from this group will be anonymised and any data used will not be personally identifiable. The background questions we would like you to complete are just for monitoring purposes, we will not match the information to individuals within the group.

Before we go any further let us reassure everyone that we do not expect you to be experts about gender identity and sexual orientation. You may not know the 'politically correct' terminology, but please feel free to discuss around the subject and do not worry too much about always saying the 'right' thing. Everyone has learning to do (including us), so don't feel like you're expected to be already familiar and comfortable talking about different gender identities and sexual orientations and their related problems.

Just to be clear: when we talk about 'sexual orientation', we are talking about identities that are related to sexual desire. These include identities such as: men who are gay, women who are lesbian, and people of either sex who are bisexual and are attracted to both genders. Furthermore, when we talk about 'gender identity', we are talking about the gender, an individual feels an increased affinity to. When we refer to people who identify as transgender, we mean people who self-identify as having a gender different from the one they were assigned at birth. When we refer to people who identify as cis-gender, we mean people who self-identify as having the same gender as the one they were assigned at birth.

And feel free to ask questions at any point – there is nothing you are necessarily expected to know and it is fine to ask for clarification.

TOPIC 1

CURRENT UNDERSTANDINGS OF **LGB** SPECIFIC HEALTH NEEDS AND BARRIERS TO HEALTHCARE.

All the following questions relate to sexual orientation minorities, specifically Lesbian, Gay and Bisexual (LGB) patients.

- **How do you think the health of patients who identify as LGB differ from the health of heterosexual patients?**
- PROMPT:
  - Can you think of any illnesses that individuals identifying as LGB are more at risk of, but are not specific to this population?
  - Do you have any ideas about <u>why</u> there are differences in the health experiences of people who identify as lesbian/gay/bisexual?
  - How do you think an individual or a group is treated could affect the health of that individual or group?

- **What behaviours and/or social experiences do you think might be different for sexual orientation minorities?**
- PROMPT:
  - Can you think of any **behaviours and/or social experiences**, like the level of exercise (smoking), that might be more or less prevalent in some minority groups? Why do you think this is? Can you think of any others?
  - Examples (not to be asked but just prompted if necessary):
    - Drugs and alcohol Patterns of alcohol consumption can be different across different social classes and age groups
    - Homelessness
    - Bullying depression
    - Supportive family/ relationship
    - Employment
    - Socio-economic status
  - Is there anything else that might affect the health of patients who identify as LGB?
  - Why do you think identifying as LGB in a mostly heterosexual world might have an effect on the wellbeing of individuals identifying as LGB?
  - What factors affect the way individuals within a community feel empowered to be open with their sexual identity? (What factors affect someone's likelihood of disclosing their minority sexual orientation?) How is this relevant to their overall health and wellbeing?
  - How may these lifestyle factors affect an individual's access to healthcare?

- **Can you think of any <u>attitudes</u> or behaviours towards individuals identifying as LGB that might affect how people access healthcare? (barriers)**
- PROMPT:
  - Can you think of ways doctors' surgeries or hospitals might be more or less welcoming to individuals identifying as LGB?
  - In what ways do you think the healthcare setting can create barriers that prevent individuals identifying as LGB from attending? In other words, why would someone who identifies as LGB not go to a particular doctors?
  - Why do you think minority populations might be more or less likely to access healthcare?
  - How do you think this marginalisation may affect their overall health?

- **Is it important for healthcare professionals to be aware of patients' sexual orientation? Why do you think this is?**

TOPIC 2

CURRENT UNDERSTANDINGS OF **TRANSGENDER** SPECIFIC HEALTH NEEDS AND BARRIERS TO HEALTHCARE.

All the following questions relate to patients identifying as transgender.

- **How do you think the health of patients who identify as transgender differ from the health of cis-gender patients?**
- PROMPT:
  - Can you think of any illnesses that individuals identifying as transgender are more at risk of, but are not specific to this population?
  - Do you have any ideas about why there are differences in the health experiences of people who identify as transgender?
  - How do you think an individual or a group is treated could affect the health of that individual or group?

- **What behaviours and/or social experience do you think might be different for patients identifying as transgender?**
- PROMPT:
  - Do you think certain **behaviours and/or social experiences**, like the level of exercise (smoking), might be more or less prevalent in some minority groups? Why? Can you think of any others?
  - Examples:
    - Drugs and alcohol Patterns of alcohol consumption can be different across different social classes and age groups
    - Homelessness
    - Bullying depression
    - Supportive family/ relationship
    - Employment
    - Socio-economic status
  - Is there anything else that might affect the health of patients who identify as transgender?
  - Why do you think identifying as transgender in a mostly cis-gendered world might have an effect on the wellbeing of individuals identifying as transgender?
  - What factors affect the way individuals within a community feel empowered to be open with their differing gender identity? (What factors affect someone's likelihood of disclosing their gender identity?) How is this relevant to their overall health and wellbeing?
  - How may these lifestyle factors affect an individual's access to healthcare?

- **Can you think of any attitudes or behaviours towards individuals identifying as transgender that might affect how people access healthcare? (barriers)**
- PROMPT:
  - Can you think of ways doctors' surgeries or hospitals might be more or less welcoming to individuals identifying as transgender?
  - In what ways do you think the healthcare setting can create barriers that prevent individuals identifying as transgender from attending? In other words, why would someone who identifies as transgender not go to a particular doctors?
  - Why do you think minority populations might be more or less likely to access healthcare?
  - How do you think this marginalisation may affect their overall health?

- **Is it important for healthcare professionals to be aware if patients identify as transgender? Why do you think this is?**

TOPIC 3

EXPERIENCE AND ATTITUDES TOWARDS UNDERGRADUATE MEDICAL TEACHING OF LGB&T HEALTH AND INEQUITIES.

- **In your medical undergraduate curriculum, what training/education have you had regarding the health needs of people from LGB&T communities?**
- PROMPT
  - Lectures?
  - Seminars?
  - Clinical exposure?
  - Extracurricular (conferences/ societies)?

- **Has identifying as transgender ever appeared as a factor of health in your medical training so far?**

- **Do you expect the teaching of health inequities of individuals from the LGB&T community to be part of your undergraduate medical education? (Why/why not?)**

- **What are your feelings towards the inclusion of more training regarding LGB&T health inequities in medical education?**
- PROMPT:
  - In what ways do you think it would help you to be an effective doctor?

Ending

Thank for your participation in the focus group. We are now going to draw it to a close, **does anyone have anything else they would like to add?**

If you have any questions or concerns about this study, please find us at the end or you can contact our supervisors using the contact details on the PARTICIPANT INFORMATION SHEET. Alternatively, you can contact BSMS student support.

The ideas and comments you have given us today will remain anonymous.

Thanks again for your help.